Editorials

Contemporary Aims for American Medicine

ELSEWHERE in this issue is the editor's report on the recent WJM forum on "The Aim of American Medicine Within the Constraints of Today's Society." As the report indicates, three aims rather than one seemed to emerge. The first, caring for patients, was a reaffirmation of what has been the raison d'être of physicians throughout history. The second, seeking good health for all, seems a more modern goal. And the third, perhaps a more avant garde idea, is that physicians can begin to use their special professional knowledge and intimate human experience to help others to find an appropriate balance when there are conflicting indications or purposes, in whatever arena, that relate somehow to health or health care. This latter aim, while perhaps new, can also be viewed as just another dimension of patient care. In fact the process to be used is quite similar to what physicians are trained to do, and do all the time when they have to balance all the conflicting factors in the technologic and human equation with a sick, injured or emotionally disturbed patient.

Or, if one preferred to consider only one aim, the forum results could be interpreted in another way. The basic aim of physicians, and therefore of the medical profession, would, in this interpretation, be to use their professional knowledge and practical experience with the human condition to achieve three purposes: (1) to provide caring and curing for the sick, (2) to seek better health for all and (3) to assist patients and society as a whole to balance conflicting needs and purposes as these pertain to health. In this interpretation, doctors should not only function as physicians to patients, but individually and collectively they should act as physician to society whether in the community, state or nation, or in the case of the nuclear threat, the world. They would also offer their expertise to help find a reasonable balance when conflicts between these two goals occur.

What seems to be needed now is a resounding reaffirmation of what medicine is all about, an even more resounding rejection of the devilish idea that dollars (the bottom line) should come first with caring in second place or even last, and then, beyond this, a conscious determination is needed to adapt the professional skills of physicians and the medical profession so as to help promote better health for all, and for the profession as a whole to develop and play a larger, and perhaps in some ways a newly defined, role as physician to society.

MSMW

Differentiating Treatable Causes of Dementia

THE SUBJECT of treatable dementia is most timely in an era of the vastly increasing segment of the aged in California and the nation. Mahler, Cummings and Benson have provided us in this issue with an excellent and comprehensive review that includes guidelines both for the recognition of reversible dementias and approaches to their treatment. Their report of treatable dementia is consistent with findings in the Alzheimer Center at the University of California, San Francisco, a tertiary clinical setting for diagnostic consultation and continuing assistance for patients with Alzheimer's disease and their families. With a few exceptions, the diagnosis of Alzheimer's disease had previously been made for the patients at this setting. A recent unpublished review of 68 consecutive patients examined there revealed that 25% of them did not have any dementing illness and were suffering in large part from affective disturbances. Very similar findings have been reported by Steel and Feldman[1] at Queens Square Hospital in London where 20% to 25% of their sample had a probably treatable illness, the most common of which was depression.

The authors note that most of the diseases of the extrapyramidal system result in cognitive and emotional difficulties. There has also been some disagreement about the degree to which there are distinguishing features between dementia resulting from cortical or subcortical involvement. In a recent study, Huber and co-workers concluded that the subcortical diseases are associated with less severe decline of intellectual and memory features and tend to show less aphasia, apraxia and agnosia than are observed in Alzheimer patients.[2] It was concluded that the subcortical illnesses were quantitatively and qualitatively different from cortical dementias and that clinical manifestations provide diagnostic and potential treatment leads.

Reisberg has suggested a systematic approach to identifying reversible causes of dementia using the approach of functional assessment staging.[3] Although he notes that more longitudinal studies of Alzheimer's are needed to better clarify the clinical progression of Alzheimer's disease, he believes that most Alzheimer patients have a characteristic progression of impairment. He has attempted to outline the characteristics of this gradual progression and postulates that if a symptom appears out of sequence, it may suggest the presence of a treatable complication of Alzheimer's disease or even a different diagnosis. It is his assumption that the course of Alzheimer's disease is predictable and that complications of other illnesses that may be reversible can be differentiated from the usual and normal progression of Alzheimer's disease.

Several approaches to differentiating reversible dementias have been studied and have not proved sufficiently promising. Dexamethasone suppression, for example, was found in 38% of a depressed group of elderly persons without evidence of dementia, but was also found in 17% of a sample of demented patients who were not depressed.[4] Similarly disappointing have been attempts to associate P3 latency in event-related potentials.[5] The importance of perfusion imaging for assessment and differential diagnosis of Alzheimer's disease is still in an early stage of development and merits further study.

The tables in the article by Mahler and coauthors are especially complete and merit continuing review in the differential diagnosis of cognitive disturbance in the elderly. It is probable that in the interest of completeness within the limits of brevity, depression, the most treatable entity which tends to be confused with dementia, receives relatively little more emphasis than other, rather rare, treatable dementias.

Roth recently cited depression as the most common single cause of complaints of impaired memory in later life.[6] He further noted that it is regularly accompanied by mild cognitive dysfunction and difficulty in concentration. He cited the